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FOR ACTION

# COUNTRY PROGRAMME RECOMMENDATION*

## Zambia

The Executive Director recommends that the Executive Board approve the country programme of Zambia for the period 1991-1995 in the amount of $7,360,000 from general resources, subject to the availability of funds, and $21,485,000 in supplementary funds, subject to the availability of specific-purpose contributions.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1990, will be contained in the "Summary of 1991 recommendations for general resources and supplementary funding programmes" (E/ICEF/1991/P/L.2).

CONTENTS

Page

The situation of children and women ..... 3

Programme cooperation, 1987-1990 ..... 4

Recommended programme of cooperation, 1991-1995 ..... 8

List of tables

1. Basic statistics on children and women ..... 16

2. Expenditure under previous cooperation period, 1987-1990 ..... 18

3. Planned expenditure, 1991-1995 ..... 19

4. Staffing from budget and programme funds ..... 20

## THE SITUATION OF CHILDREN AND WOMEN

1. The programme has been prepared during a momentous period of political change and economic reforms. In September 1990, after a vigorous national debate, it was announced that Zambia would change to a multi-party system. A commission is working on the required changes in the constitution and elections are scheduled for 1991.

2. The recent energy crisis, which resulted in a 400 per cent increase in domestic fuel prices, has further exacerbated long-standing economic problems. Per capita income is now estimated to be less than $300. In 1989, Zambia initiated an economic reform programme of fiscal and monetary restraint and revenue enhancement measures, together with a restructuring of economic incentives to stimulate production. The economy remains extremely vulnerable to external shocks. Agricultural production is largely dependent on rainfall, and a major drought would seriously threaten food security and could even halt the tentative economic recovery process. The external debt exceeds $7 billion, almost four times the gross national product (GNP), and, therefore, high international interest rates have serious consequences for the country.

3. The impact of adjustment and external economic shocks on children and women, especially the urban poor, is severe. The decontrol of prices, the elimination of subsidies and the energy crisis have dramatically increased the prices of essential items such as transport, food, rents and utilities. The annual inflation rate in 1990 was estimated to be 120 per cent. Basic services are increasingly under pressure since budget allocations do not keep pace with inflation, and both the quality and coverage of services have been adversely affected by low pay and the exodus of trained staff. To mitigate the potentially serious impact of adjustment on the poor and vulnerable and to facilitate the participation of the poor in the economic recovery, the Government established a social action programme as an integral part of the public investment programme for 1990-1994 which covers health and nutrition; education; water and sanitation; urban and rural roads; market places and transport; women in development; income and employment through accelerated public works projects; and the development of small-scale enterprises.

4. In spite of economic difficulties and past geopolitical problems, Zambia has made substantial progress in improving social services and the welfare of children and women. The under-five mortality rate dropped from 228 per 1,000 live births in 1960 to 125 in 1989, access to health care improved owing to a network of over 1,000 health facilities and universal child immunization (UCI) was reached in 1988. This progress is now threatened by the economic crisis and by the spread of acquired immunodeficiency syndrome (AIDS), which may even reverse these achievements. According to UNICEF field office estimates, AIDS could increase the child death rate by 20 per cent or more in the coming years. Other major causes of infant and child mortality include disorders of the new-born and perinatal period, respiratory infections, diarrhoeal diseases, malnutrition, malaria and measles.

5. The principal causes of maternal mortality, which is estimated to be 200 per 100,000 live births, are related to infection and poor pre-natal care, rather than to the physical complications of pregnancy. The World Health Organization (WHO) estimates that the death rate among women of child-bearing age will increase 200 to 300 per cent in countries where human immunodeficiency virus (HIV) infection is high.

6. Both moderate and severe malnutrition rates, which are traditionally high at 25 to 30 per cent, are also thought to be increasing as a result of several factors, including deteriorating economic conditions, inflation, the reduction of food subsidies and the rapid spread of HIV infection.

7. Primary school enrolment remains high (over 90 per cent), but enrolment steadily declines up to the seventh grade (the end of primary school), so that less than 80 per cent of children complete primary school. In rural areas, the progression rates from grade 4 to grade 5 are significantly low. The illiteracy rate has declined from about 70 per cent at independence in 1964 to around 25 per cent, but there are still more than 1 million illiterates, of whom some two thirds are women.

8. Zambia is already more than 50 per cent urbanized. Annual urban population growth is 6 per cent, four times faster than the rural population, which places a great strain on urban services. The densely populated squatter areas lack access to water, sewage and drainage. The estimates of access to clean water (40 per cent of the rural population and 76 per cent of the urban population) are probably too high.

9. Growing numbers of children are being orphaned by AIDS, and estimates suggest that tens of thousands of children may be affected over the next five years. Many of those children will be in urban areas and this is likely to create a major problem of street children.

## PROGRAMME COOPERATION, 1987-1990

10. The country programme for 1987-1991 has been reduced to four years because the annual programme budget levels were increased and the approved funds were disbursed ahead of schedule. Implementation of some components has been slow, and some redesigning was necessary in order to reformulate certain objectives and strengthen implementation capacity.

11. The maternal and child health (MCH)/UCI project represented roughly 75 per cent of the total UNICEF financial input. Initial progress was very encouraging. A national survey in 1988 showed that UCI had already been achieved and sentinel sites reported a decline in disease incidence. However, a combination of recurrent budget limitations, logistic and organizational problems, competing health priorities and slackening social mobilization led to a decline in vaccination coverage in 1989. This trend was reversed in 1990 as a result of intensified social mobilization, focusing on national immunization days, and increased technical and financial support. Cooperation

with the Church Medical Association of Zambia, which is responsible for up to 40 per cent of rural health care, was very positive in the control of diarrhoeal diseases (CDD) and MCH/UCI, including the training of traditional birth attendants (TBAs) and child health workers, and more recently in health financing and district management.

12. The CDD project emphasized training. Some 70 district trainers were equipped to undertake UCI/CDD training in their districts where they, in turn, organized training for 1,100 health workers in case management, use of oral rehydration therapy (ORT) and communication. The Diarrhoea Training Unit opened in 1990. Problems experienced in the local production and distribution of oral rehydration salts (ORS) are being addressed by an inter-agency working group. The use of ORS increased from 1 million sachets in 1986 to 3.5 million in 1990, and a local production capacity has been created that can meet approximately 35 per cent of this consumption.

13. The sexually transmitted diseases (STDs) project supported a national network of more than 40 STD clinics, with joint training programmes and the provision of laboratory kits. Intensive counselling and health education efforts in antenatal clinics have increased service quality, and 30 clinical officers have been trained.

14. The national nutrition surveillance programme, which has provided regular growth monitoring, aims to increase the effectiveness of nutrition activities within primary health care (PHC) and to influence policy makers and planners to take nutrition-related factors into account in designing development policies and programmes. However, activities have been constrained by under-staffing, the lack of office space and computers, logistics problems and inadequate recurrent budgets. Following a technical review supported by the Government of Sweden, the programme is being reoriented, with priority being given to improving the quality and effectiveness of growth monitoring and its extension to the community, and to intensifying practical measures for the prevention and treatment of child malnutrition.

15. In the health sector, the major implementation problems were weak coordination and management capacities, lack of technical expertise in specific areas, staff shortages, inadequate monitoring and health information systems, lack of recurrent budgets and deficient accounting and disbursement procedures.

16. The household food production and income-generation project assisted 600 women in three districts. The women are organized in groups of 20, according to the national lima (a farming system) group development strategy. Although agricultural production increased, the project had limited lasting impact on women's welfare and has experienced managerial and implementation problems. The project structure is not sustainable; the revolving fund has not operated effectively and the system for input distribution tended to encourage dependency of the beneficiaries on the donor agency supply line. Furthermore, in the field, the project has been perceived as a UNICEF project and has not been integrated fully into the mainstream activities of the

Ministry of Agriculture. Modifications are being made to ensure that by 1992 these women's groups can link up with the cooperative movement or other local structures that can provide advice and inputs.

17. The integrated rural women's education and child survival and development (CSD) project has assisted 400 women, usually heads of household, in two districts of Luapula Province. Managed by a national coordinator in the Provincial Planning Unit, the project has faced coordination problems between planners and line ministries, delays in the delivery of inputs, slow disbursement and weak institutional support. Nevertheless, agricultural production and access to health care have improved in the participating communities and a basis has been established for project expansion. The problems encountered have been addressed by a review team whose recommendations for a comprehensive redesign have been incorporated into the new programme.

18. The child-to-child project used children to communicate health messages to other children, as well as to the family and community. Initial management problems have been overcome through training and the reallocation of responsibilities. The project has developed close ties with the Curriculum Development Centre and the Ministry of Health and has worked mainly through six teacher-training colleges and 25 associated schools. Targeted training of teachers was conducted and links are being developed with the family and community. In Mpika and other districts, sketches and songs by child-to-child groups at schools have informed mothers about immunization and other health activities.

19. The functional literacy project supported literacy and training for women and girls through the network of social development centres and women's clubs. Activities included the development of materials and the strengthening of supervision, sensitization seminars and baseline data collection. A major review of literacy activities and learning opportunities for women and girls has been completed, of which the results form the basis of a new national strategy to reduce illiteracy.

20. The planning, monitoring and evaluation project has strengthened planning, data collection and analysis in areas such as food and nutrition policy as related to the adjustment programme. A survey of malnutrition was conducted in conjunction with the periodic crop forecasting survey and a bulletin of socio-economic indicators and analysis is being published.

Lessons learned

21. In programme design, there is a need for more attention to project management issues, including coordination, communication, supply and logistics, as well as to ensuring a better match between project objectives and available human and financial resources. Recurrent budget allocations need to be increased, either from domestic or external sources, and disbursement and accounting procedures should be streamlined.

22. Social mobilization has demonstrated its potential for mobilizing support for UCI. Here the personal involvement and commitment of the top leadership has been decisive and must be maintained. The progress in immunization also demonstrates the value of a clear focus and well-understood objectives, supported by careful planning and monitoring and the strengthening of delivery systems. The use of targets is a powerful mobilization and managerial tool, but requires the strengthening of monitoring and routine information systems so that progress can be measured. The experience of the present programme indicates that staffing, both in quality and quantity, is a decisive factor. Training needs to be more professionally organized, with increased involvement of training institutions and more attention to management skills such as budgeting and supervision, as well as technical areas.

23. There must also be supportive personnel and training policies reinforced by a strengthened supervisory system. To conserve scarce management time, resources should be concentrated on flexible sectoral programmes, rather than fragmented among separate projects. For more efficient management, implementation responsibilities, along with the required resources, should be decentralized wherever possible to the locus of action, usually the district or community level.

24. The present programme underestimated the severity and duration of the economic crisis. The new programme is based on a more realistic appraisal of available national and local resources. It includes targeted support for recurrent budgets and improved cost monitoring and analysis in the framework of strategies to mobilize domestic resources in the medium term, including the reallocation and expansion of central budgets and increased district and community financing. A costing study of immunization and a report on existing community financing initiatives and their potential for expansion have been prepared.

25. Another major lesson of the present programme is that activities to increase the income and improve the conditions of women must be better adapted to the prevailing economic environment, and require technical guidance in areas such as credit, marketing and technology. In these projects, and also in relatively new programme areas such as AIDS and informal education, closer collaboration should be sought with church groups and non-governmental organizations (NGOs), who are accomplishing pioneering work.

RECOMMENDED PROGRAMME OF COOPERATION, 1991-1995

Recommended general resources: $ 7,360,000
Supplementary funds: $21,485,000

Recommended programme cooperation a/

(In thousands of United States dollars)

| | General resources | Supplementary funds b/ | Total |
|---|---|---|---|
| Primary health care | 3 310 | 11 700 | 15 010 |
| Basic education | 1 840 | 7 500 | 9 340 |
| Planning and social statistics | 735 | - | 735 |
| Community-based child survival and development | 1 475 | 2 285 | 3 760 |
| Total | 7 360 | 21 485 | 28 845 |

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Programming process

26. The proposed programme is based on a review of the present programme and on the situation analysis of children and women, and the goals and priorities are consistent with the Fourth National Development Plan (1989-1994) and the social action programme. Major bilateral donors have also been involved. The programme builds upon the experience gained during the present cycle, and seeks to strengthen the positive features and overcome the implementation problems encountered.

Programme strategy

27. The programme contributes to the national effort to reduce under-five and maternal mortality and morbidity, although the achievement of specific reduction targets may not to be feasible in view of the spread of AIDS and the extent of poverty. The programme strategy responds to the main causes of child and maternal deaths: poor quality and coverage of services, especially health (PHC); poor socio-cultural conditions, especially lack of education, information and low status of women (Education for All); and household poverty, food insecurity and malnutrition (community-based child CSD).

28. The country programme consists of national programmes in health, education and social planning, in addition to an area-based programme composed of district-specific rural and urban community-based projects. The emphasis is on strengthening programme planning and management, including the budget process and monitoring and evaluation, and on the more efficient and effective use of existing resources and infrastructure. It reflects the "adjustment with a human face" strategy of protecting essential services, food security and incomes of the poorest and of monitoring social indicators. Intensive efforts will be made to ensure maximum complementarity and synergism between major programme components. Successful community-based approaches developed in the area-based programme will be integrated into the national programmes, while the planning and social statistics project will use field information gained from the other programmes.

29. The major part of UNICEF investment goes to interventions with a direct impact on poor children and women, but in recognition of the need to refine policy goals and targets and to strengthen systems, the programme also supports policy development and analysis (including innovative pilot activities) and capacity-building (including government and non-government institutions, rural and urban district administration and community organizations).

30. Social mobilization is an integral part of the programme. The aim is to strengthen national commitment to, and popular support and demand for, CSD and to improve implementation through the development of communication networks. Social mobilization is especially important in the prevention of AIDS and the promotion of education for all. Priority will be placed on harnessing the potential of "third channel" learning opportunities such as churches, women's groups and the media. The notions of a "learning society", the "empowerment" of communities and the building of confidence through knowledge are central to the programme strategy. Another theme that will strongly influence programme targetting is disparity reduction in general, with a special emphasis on the gender gap.

Programme objectives and goals

31. The overall goals are: (a) to reduce child mortality and improve child health; (b) to reduce maternal mortality and to improve women's health; (c) to develop effective methods to reduce poverty and malnutrition, with the participation of the poor; (d) to strengthen decentralized district management of services and to develop a framework for community-based management; and (e) to reduce illiteracy and to expand access to basic education and learning opportunities for primary school-age children, adolescents and women.

32. The programme does not specify quantitative nutritional objectives because of the fluidity of the situation. However, it has the general objective of preventing an increase in malnutrition and gradually reducing its high prevalence. Furthermore, if the specific goals of each project are achieved, the economy improves and adequate social policy is implemented by the year 2000, Zambia may achieve the following global nutritional goals:

(a) the reduction of both moderate and severe undernutrition to one half of 1990 levels; (b) the virtual elimination of vitamin A and iodine deficiency; and (c) the reduction by 30 per cent of iron deficiency anaemia in women.

Health

33. The PHC programme incorporates the Bamako Initiative strategy and aims to reduce mortality and morbidity of children and women through nation-wide interventions, with integration at district and health centre levels, and the development of systems for community management and financing. At the service provision level, support will strengthen PHC delivery, especially specific services such as immunization. At the institutional level, the focus is to increase the capacity of human and organizational systems to support PHC, including national institutions. At the policy level, the programme will support the development of government policies to respond best to health needs and to mobilize resources for health.

34. The objective of the maternal health/safe motherhood programme is to reduce maternal and perinatal mortality and morbidity by improving the coverage and quality of care, with an emphasis on high-risk individuals and groups. The status of women will be enhanced by providing information on health services and practices to protect their health. Staff training and the provision of equipment and diagnostic facilities will improve the quality of antenatal and post-natal care as part of an integrated PHC package, identifying high-risk women. This is part of the national MCH programme that is supported by the United Nations Population Fund (UNFPA) and WHO. TBAs will be trained to provide safe home deliveries and to play an important educational and mobilizing role. The prevention of maternal deaths will be assured through the referral of high-risk cases for obstetric care at appropriate levels of the existing health delivery system, although direct support in this area will be provided by other donors. UNFPA will support the family health programme, which places emphasis on birth spacing through MCH services and NGO channels. Coordination will be important in community education and mobilization, as a contribution to the empowerment of women. The importance of women's health, adequate care for all pregnancies and referral of high-risk cases for institutional delivery will be emphasized in all education and mobilization activities. Young girls will be a specific target group. The prevention of future high-risk pregnancies and the spacing of births will be highlighted. Problems related to AIDS will be addressed in an integrated fashion by training health workers to detect and refer suspected cases for diagnosis and care. Community-based home care will be promoted. The protection of health workers and other patients from infection by contaminated instruments, hands, etc., will be assured through the provision of adequate equipment (including gloves) to staff at risk and TBAs, with appropriate training in their use. Close cooperation will be maintained with the WHO-supported National AIDS Prevention and Control Programme.

35. The UCI objective is to reduce mortality and morbidity specifically through maintaining the coverage and improving the quality of the expanded programme on immunization, including tetanus toxoid vaccine for women, with a special emphasis on the elimination of neonatal tetanus and polio in this decade. Service quality will be improved through training and supervision, especially in those areas with poorer results, to ensure strict application of vaccine schedules and norms. Better use of staff in static units, including hospitals, through integrated training in PHC/UCI, will permit more vaccination sessions and greater availability of vaccines, thus reducing missed opportunities. Attention to the control and maintenance of the cold-chain system will assure vaccine efficiency through the service delivery level, while studies of vaccine efficacy are planned. Equipment and transport will be provided. The training of managers at district and health centre levels will ensure better supervision and training, adequate supplies, proper storage of vaccines and active monitoring of information for better management. Evaluation activities, periodic surveys and appropriate operations research will supplement routine data collection.

36. The objective of the CDD programme is to reduce mortality, morbidity and malnutrition caused by diarrhoeal diseases. Resource utilization will be improved through integrated training, supervision and monitoring for PHC/CDD. Training in the Diarrhoea Training Unit will target staff and managers. Better case management, including the face-to-face education of care-givers, will result from in-service training and the integration of CDD into PHC training and supervisory activities, with the establishment of ORT corners in all health facilities. Inter-agency coordination will result in better management of the ORS supply chain. Community education and mobilization will be strengthened and extended to include other PHC components. The prevention of diarrhoeal diseases through improved hygiene practices will form part of the educational message. Community-supported water and sanitation interventions will be promoted, especially in urban areas, building on the example of the neighbourhood mothers' project at Lusaka, where women volunteers have been trained to promote ORT and basic hygiene measures.

37. The objective for the nutrition programme is to reduce child mortality and morbidity and promote growth through early detection and correction of growth faltering, as well as early detection and rehabilitation of malnutrition. A decrease in malnutrition is sought through an integrated PHC approach to child health. Growth monitoring and promotion, with counselling and adequate case management as integral parts of PHC services, will be achieved through staff training and support. Training will help to reduce the high fatality rate in severely malnourished children. Face-to-face nutrition education by health staff will be strengthened and other channels will be used to influence community practices in key areas such as infant feeding. Intersectoral activities will be promoted to address identified nutrition problems in pilot areas through the utilization of the "Triple A" approach (continuous assessment, analysis and action). The training of child health workers and TBAs as front-line workers for screening and referral will be carefully evaluated, as experience to date has indicated problems in the areas of motivation and support. Vitamin A and iodine deficiency will be addressed

through the development of national strategies and support for implementation in affected areas.

38. Another project aims to develop replicable activities to strengthen PHC services and management in selected districts. Such activities will include locally based financing systems with greater community involvement in management. The quality of PHC will be improved through regular availability of drugs, increasing the motivation and skills of health workers and improved training and supervision. The services will include UCI, CDD, MCH, nutrition, malaria and acute respiratory infections. Management of PHC will be strengthened at the district level, particularly in planning, supervision and monitoring, by building on the existing district management team. Intersectoral linkages, training and exposure to other experiences will facilitate the use of approaches for identifying and solving problems with communities. Financial resources for PHC will be mobilized at the community level through the introduction and testing of community financing schemes. In line with decentralization policies, revenues will be retained at the facility level. The flow of resources from central to district level will also be streamlined, as will the management of district-level financing. These efforts will be supported by advocacy and related actions for increased government budgetary support to PHC. Community participation in PHC management will be promoted through education and mobilization in order to increase community understanding and the use of PHC services by building on existing community-financing mechanisms to increase local responsibility for locally generated revenues and by improving the capabilities and motivation of child health workers and TBAs to address community health needs. Learning from experience is essential for the introduction of alternative approaches to PHC management. Monitoring and evaluation will be complemented by operational research to identify effective service delivery and management approaches. Institutional linkages will be made to carry out research and provide training links with other innovative PHC activities.

39. With an emphasis on strengthening national expertise to ensure the overall long-term development of the PHC programme, collaboration will be encouraged among concerned organizations and institutions from the central to the community level. This should achieve clearer shared definitions of goals and objectives and more efficient resource utilization. Similarly, the effective integration in PHC planning and implementation will be supported, especially in key activities such as management and health information systems that will catalyse broader action and provide inputs relevant to national policy decisions. Support for the collection and utilization of appropriate information in order to learn from experience and try out new ideas will be reflected in all activities.

40. Because the socio-economic impact of the spread of AIDS and the implications for women and children are still not fully understood, the "children in distress" component will support research and data collection, as well as pilot operational activities in affected communities. The main problems to be addressed are the growing number of AIDS orphans (expected to exceed 100,000 within the duration of the programme) and of HIV infected

children, as well as the need to support families coping with the social, psychological and economic pressures of terminally ill family members. The scale of the problem requires the mobilization and strengthening of new partners, especially NGOs and community-based groups, through training, institutional support and exchanges of experience. A coalition of interested NGOs and community leaders is already starting activities at Lusaka. The project will be implemented within the framework of the WHO-supported National AIDS Prevention and Control Programme.

Education for All

41. The Government is in the process of defining a national strategy and plan, with the following goals for the year 2000: (a) to enrol all primary-school-age children in primary school or its equivalent; (b) to retain all primary-school-age children in school for the equivalent of seven grades; (c) to reduce the adult illiteracy rate to one half the present rate; (d) to reduce the female illiteracy rate to equal the male rate; and (e) to provide life skills training for youth and adults. Within this framework, this programme aims: (a) to increase the progression rate at the end of grade four in 1995 to 95 per cent of grade one intake in 1992; (b) to ensure that all 10-year-old children achieve or surpass competencies defined for grade four or its equivalent by the year 1995; (c) to reduce the adult illiteracy rate from 25 per cent in 1990 to 20 per cent in 1995; (d) to reduce the female illiteracy rate from 33 per cent in 1990 to 22 per cent in 1995; and (e) to focus learning activities on out-of-school youth, particularly 11 to 15 year olds.

42. The learning achievement component focuses on the development and production of learning materials. Support will be targeted to the most urgent needs, beginning with materials for primary schools that focus on life skills (using Facts For Life messages). Workbooks and selected supplementary readers will be produced in English and in four local languages for grades one to four. An Education for All magazine will also be produced to permit the exchange of information between schools and to narrow the gap between formal and non-formal education. NGOs, churches and other groups will be involved in informal learning activities to reach underserved groups. Innovative and cost-effective measures will also be developed to meet the shortfall in the provision of education facilities, especially for the most vulnerable. Such measures include intensification of the child-to-child approach, multi-grade teaching and tight timetabling. School community linkages will be strengthened through the Parent-Teacher Association movement. This will increase community participation in the education system in general, with particular attention to early childhood development. Intersectoral linkages will be reinforced and there will be greater complementarity between formal and non-formal education. In-service teacher training will reorient teachers to new methods of teaching and utilization of new materials. Improved assessment techniques will be developed to evaluate learning achievement. Attention will be drawn to educational disparities and deprivation through workshops and seminars, the mass media and studies on marginalized groups and on the impact of adjustment.

43. The component on learning opportunities, particularly for women and girls, will focus on demand-driven functional literacy that responds to the needs of women's groups, in particular, and out-of-school children and adolescents. In this process, post-literacy and informal learning opportunities and efforts to apply literacy skills to daily life and the social environment are important. Support to learners will be emphasized, thus enabling them to acquire basic literacy and numeracy skills, apply those skills to self-improvement and productive activities, and develop critical awareness of their situation. Recognizing the diverse needs of youth and adults, the project will develop a variety of delivery systems, including NGOs and churches. Linkages between formal and non-formal education, along with linkages with other development initiatives, will be strengthened. A particular effort will be made to involve local administrations in developing community participation and utilizing local resources and facilities. Learning material packages, beginning with life skills (using Facts For Life), will be produced in both English and local languages, and training will be provided for instructors, supervisors and other key staff.

Planning and social statistics

44. The project will strengthen the capacity for the analysis of social issues, supported by a system for monitoring social indicators at national, district and community levels, which can provide a reliable and timely flow of information. High priority will be given to monitoring progress towards the goals and strategies for children and development in the 1990s as endorsed by the World Summit for Children.

Community-based child survival and development

45. This programme aims: (a) to increase income and food security through training and access to information and credit; (b) to enhance early child development through community- and home-based child care; (c) to improve infant nutrition through the promotion of exclusive breast-feeding and improved weaning and supplementary feeding practices; (d) to improve environmental sanitation with protected water supplies, improved pit latrines and hygiene education; (e) to support site-specific adaptations of PHC and Education for All programmes; (f) to develop an effective and replicable methodology for sustainable community-based development; and (g) to develop district planning and management processes and a responsive service system supportive of community-based development.

46. The programme directly addresses the problems of poor urban and rural households, particularly those headed by women. It seeks to improve on past experience by changing the focus from small groups to communities through working more directly with district administration and community groups. Initially, the programme will select disadvantaged communities in the urban district of a secondary city and several rural districts in Luapula Province, which has a high proportion of households headed by women and the highest malnutrition rates in the country. An important feature is the development of district planning and implementation processes, which are supportive of

community-based development. This will include policy advocacy and orientation activities at all levels to encourage greater decentralization of health, education and social services. The district administration will be encouraged and supported to work directly with community-based organizations and to develop service systems that are responsive to felt needs in the community and supportive of community initiatives.

Advocacy

47. The programme will offer opportunities for advocacy for issues of global concern for children, including those not addressed by substantive programmes. The Government is preparing for the ratification of the Convention on the Rights of the Child. A study is being undertaken by leading Zambian lawyers on existing national legislation concerning children and on the process for incorporating the Convention into Zambian legislation. UNICEF will support research and sensitize decision makers on issues concerning women, the impact of adjustment on vulnerable groups, orphans, education (especially for girls) and the environment. Parliamentarians will be a key target group. The initial centrepiece for policy advocacy and action will be the development of a national programme of action for children based on the Declaration of the World Summit for Children.

Cooperation with the United Nations and other organizations

48. The programme has been developed in close cooperation with the United Nations system in order to strengthen coordination and enhance the complementarity of the inputs of the various agencies. Inter-agency cooperation will be strengthened, especially on cross-cutting issues such as adjustment, food and nutrition and women, with the partners of the Joint Consultative Group on Policy. WHO is cooperating closely in areas such as EPI, CDD, MCH, AIDS, district management and the Bamako Initiative. UNFPA is a close partner in MCH and family planning. Collaboration with the United Nations Educational, Scientific and Cultural Organization has been greatly reinforced by the Education for All initiative. Complementarity is being sought with the World Food Programme in the supplementary feeding of malnourished children in health centres. With the Food and Agriculture Organization of the United Nations and the International Labour Organisation, there is close cooperation on household food and income issues, including national food strategies, household food security, income generation and skills training. Key bilateral agencies such as the Swedish International Development Authority, the Norwegian Agency for International Development, the Finnish Agency for International Development, the Canadian International Development Agency, the Japan International Cooperation Agency, the Overseas Development Administration (United Kingdom), the United States Agency for International Development, Dutch Cooperation and the German Agency for Technical Cooperation, have participated in programme preparation to ensure close coordination and collaboration in programme delivery.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Zambia (1989 and earlier years) — UNICEF country classification

| | | | |
|---|---|---|---|
| Under-five mortality rate | 125 | (1989) | High U5MR |
| Infant mortality rate | 78 | (1989) | High IMR |
| GNP per capita | $ 290 | (1988) | Low GNP |
| Total population | 8 million | (1989) | |

| KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT | | 1970 | 1980 | 1985 | 1989 |
|---|---|---|---|---|---|
| Births | (thousands) | 206 | 288 | 344 | 403 |
| Infant deaths (under 1) | (thousands) | 22 | 26 | 29 | 31 |
| Under-five deaths | (thousands) | 35 | 42 | 46 | 50 |
| Under-five mortality rate (per 1,000 live births) | | 172 | 146 | 135 | 125 |
| Infant mortality rate (under 1) (per 1,000 live births) | | 108 | 91 | 84 | 78 |

| | | About 1980 | Most recent |
|---|---|---|---|
| Underweight children (under 5) (% weight for age, 1980/1990) | Moderate & severe | .. | 25* |
| | Severe | .. | 5* |
| Babies with low birth weight (%, 1971-1972/1987) | | 14 | .. |
| Children completing primary level (% of first grade, 1980/1986) | | 85 | 91 |

| NUTRITION INDICATORS | | About 1980 | Most recent |
|---|---|---|---|
| Mothers breast-feeding at 3/6/12 months (%, 1980/1985) | | ../../.. | ../../ 93* |
| Prevalence of wasting (%, 1980/1990) | | .. | 10* |
| Prevalence of stunting (%, 1980/1990) | | .. | 59* |
| Daily per capita calorie supply (% of requirements, 1979-1981/1984-1986) | | 95 | 92 |
| Food production per capita index (Index 1979-1981=100, 1980/1989) | | 103 | 96 |
| Household expenditure (% of total income, 1980-1985) | All food/cereals | | 37/ 8 |

| HEALTH INDICATORS | | About 1980 | Most recent |
|---|---|---|---|
| ORT use rate (%, 1987-1988) | | | 59 |
| Access to health services | Total | .. | 75 |
| (% of population, 1980/1983) | Urban/rural | ../.. | 100/50 |
| Access to safe water | Total | .. | 59 |
| (% of population, 1980/1985) | Urban/rural | ../.. | 76/41 |
| Access to adequate sanitation | Total | .. | 56 |
| (% of population, 1980/1985) | Urban/rural | ../.. | 76/34 |
| Births attended by trained personnel (%, 1980/1986) | | .. | 39* |
| Maternal mortality rate (per 100,000 live births, 1979/1983) | | .. | 150 |

| Immunization | | 1981 | 1985 | 1988 | 1989 |
|---|---|---|---|---|---|
| One-year-olds (%) immunized against: | Tuberculosis | 72 | .. | 92 | .. |
| | DPT | 44 | .. | 83 | .. |
| | Polio | 77 | .. | 81 | .. |
| | Measles | 21 | .. | 80 | .. |
| Pregnant women (%) immunized against | Tetanus | .. | .. | .. | .. |

TABLE 1 (continued)

Zambia

| EDUCATION INDICATORS | | About 1980 | Most recent |
|---|---|---|---|
| Primary enrolment ratio (gross/net) | Total | 98/ 84 | 97/ .. |
| (%, 1980/1986) | Male | 103/ 86 | 102/ .. |
| | Female | 92/ 81 | 92/ .. |
| Secondary enrolment ratio (gross/net) | Total | 17/ .. | ../ .. |
| (%, 1980/1988) | Male | 22/ .. | ../ .. |
| | Female | 12/ .. | ../ .. |
| Adult literacy rate, 15 years & older | Total | 52 | 67 |
| (%, 1970/1985) | Male/female | 66/ 37 | 77/ 59 |
| Radio/television sets | | | |
| (per 1,000 population, 1980/1988) | | ../13 | 74/15 |

| DEMOGRAPHIC INDICATORS | | 1970 | 1980 | 1985 | 1989 | 2000** |
|---|---|---|---|---|---|---|
| Total population | (millions) | 4.2 | 5.7 | 7.0 | 8.1 | 12.3 |
| Population aged 0-15 years | (millions) | .. | 3.0 | 3.6 | 4.2 | 6.3 |
| Population aged 0-4 years | (millions) | .. | 1.1 | 1.4 | 1.7 | 2.4 |
| Urban population (% of total) | | 30 | 40 | 45 | 49 | 59 |
| Life expectancy at birth | Total | 46 | 50 | 52 | 54 | 59 |
| (years) | Male | 45 | 49 | 51 | 53 | 57 |
| | Female | 48 | 52 | 54 | 55 | 60 |
| Total fertility rate | | 6.8 | 7.2 | 7.2 | 7.2 | 6.6 |
| Crude birth rate (per 1,000 population) | | 49 | 51 | 51 | 51 | 46 |
| Crude death rate (per 1,000 population) | | 19 | 16 | 14 | 13 | 10 |

| | | About 1980 | Most recent |
|---|---|---|---|
| Contraceptive prevalence rate | | 1 | .. |
| (%, 1977/1987) | | | |
| Population annual growth rate | Total | 3.1 | 3.9 |
| (%, 1965-1980/1980-1989) | Urban | 7.1 | 6.3 |

| ECONOMIC INDICATORS | | About 1980 | Most recent |
|---|---|---|---|
| GNP per capita annual growth rate | | -1.2 | -4.9 |
| (%, 1965-1980/1980-1988) | | | |
| Inflation rate (%, 1965-1980/1980-1988) | | 6 | 34 |
| Population in absolute poverty | Urban/rural | ../ .. | 25/ .. |
| (%, 1977/1988) | | | |
| Household income share | Top 20%/bottom 40% | 61/ 11 | ../ .. |
| (%, 1976/1988) | | | |
| Government expenditure | Health/education | 6/ 11 | 5/ 8 |
| (% of total expenditure, 1980/1987) | Defence | .. | .. |
| Household expenditure | Health/education | | 5/ 6 |
| (% of total income, 1980-1985) | | | |
| Official development assistance: | $US millions | 318 | 477 |
| (1980/1988) | As % of GNP | 10 | 22 |
| Debt service | | | |
| (% of goods & services exports, 1980/1988) | | 18 | 14 |

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1987-1990

(In thousands of United States dollars)

COUNTRY: ZAMBIA
LATEST BOARD APPROVAL: 1987
GENERAL RESOURCES: $2,950,000

| | Supplies and equipment (incl. freight) | | Training grants | | Project staff | | Other cash | | Totals | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | GR | FSF | GR | FSF | GR | FSF | GR | FSF | GR | FSF | Total |
| Health | 1083 | 4463 | 172 | 145 | 360 | 584 | 360 | 964 | 1975 | 6156 | 8131 |
| Water supply and sanitation | | 1 | | | | | | | | 1 | 1 |
| Nutrition | 145 | 46 | 46 | | 5 | | 36 | | 232 | 46 | 278 |
| Education | 106 | | 55 | | 17 | | 62 | | 240 | | 240 |
| Community organization and development | 189 | 152 | 40 | 9 | 2 | 46 | 41 | 55 | 272 | 262 | 534 |
| Women-centred programme | 5 | | 12 | | | | 19 | | 36 | | 36 |
| Children in especially difficult circumstances | | 16 | | | | | | | | 16 | 16 |
| Emergency | | 45 | | | | | | | | 45 | 45 |
| Planning and project support | 47 | | 1 | | 63 | 27 | 179 | 57 | 290 | 84 | 374 |
| Freight | 87 | 523 | | | | | | | 87 | 523 | 610 |
| GRAND TOTAL | 1662 | 5246 | 326 | 154 | 447 | 657 | 697 | 1076 | 3132 | 7133 | 10265 |

GR = General resources.
FSF = Funded supplementary funding.

/...

TABLE 3. PLANNED EXPENDITURE, 1991-1995

(In thousands of United States dollars)

| Country: ZAMBIA<br>Period covered: 1991-1995 | Funding status | 1991 | 1992 | 1993 | 1994 | 1995 | Total |
|---|---|---|---|---|---|---|---|
| Health | GR | 690 | 662 | 660 | 658 | 640 | 3310 |
| | FSF | 1785 | | | | | 1785 |
| | NSF | 2223 | 2757 | 2446 | 2208 | 2066 | 11700 |
| Education | GR | 375 | 370 | 368 | 368 | 359 | 1840 |
| | NSF | 1400 | 1500 | 1700 | 1700 | 1200 | 7500 |
| Planning and social statistics | GR | 122 | 140 | 149 | 151 | 173 | 735 |
| Integrated area-based programme | GR | 285 | 300 | 295 | 295 | 300 | 1475 |
| | FSF | 98 | | | | | 98 |
| | NSF | 400 | 425 | 465 | 490 | 505 | 2285 |
| TOTAL | GR | 1472 | 1472 | 1472 | 1472 | 1472 | 7360 |
| | FSF | 1883 | | | | | 1883 |
| | NSF | 4023 | 4682 | 4611 | 4398 | 3771 | 21485 |
| GRAND TOTAL | | 7378 | 6154 | 6083 | 5870 | 5243 | 30728 |

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

| COUNTRY: ZAMBIA | Number of posts | Amount (thousands of United States dollars) |
|---|---|---|
| FINANCED FROM 1992-1993 PROPOSED BUDGET: | | |
| International Professional established posts | 3 | 673 |
| Local national Professional and General Service established posts | 14 | 311 |
| Operating costs | | 537 |
| Total | 17 | 1521 |
| FINANCED FROM PROGRAMME FUNDS: a/ | | |
| International Professional project posts | | |
| General resources | 5 | 1036 |
| Supplementary funds | 1 | 203 |
| Local national Professional and General Service project posts | | |
| General resources | 17 | 346 |
| Supplementary funds | 5 | 102 |
| Total | 28 | 1687 |

a/ For information source, see 1992 post authorization table, dated January 1991.

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